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Surveillance to reproductive health in the Family Health Strategy

Vigilância à saúde reprodutiva na Estratégia Saúde da Família

Atención a la salud reproductiva en la Estrategia Salud de la Familia

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Abstract

Objective: To analyze the practice of reproductive health surveillance in the Family Health Strategy program, in the scenario of Cuiabá, Mato Grosso. **Methods:** An exploratory, qualitative study. We performed participative observation of the practices into the areas of two health teams, from January to June 2012. On the examination of the empiric, content thematic analysis was used. **Results:** Surveillance actions were carried out mostly by Health Community Agents (HCA) through home visits to pregnant and postpartum women, with the purpose of controlling reproductive diseases and promote self-care. Its most advanced feature was the facilitation of access of women to the strategic actions of the local service. The production of information on reproductive health, although systematic, was not used by the workers to guide the local health actions. **Conclusion:** The surveillance practice analyzed proved to be limited, although enlarged compared to the traditional active search for prenatal care and epidemiological surveillance of controlled diseases.

Keywords: Surveillance; Health Promotion; Reproductive Health; Family Health Program.

Resumo

Objetivo: Analisar a prática de vigilância à saúde reprodutiva na Estratégia Saúde da Família, no cenário de Cuiabá, Mato Grosso. **Métodos:** Estudo exploratório, qualitativo. Realizou-se observação participante das práticas em territórios de duas equipes de saúde, de janeiro a junho de 2012. No exame do empírico, utilizou-se a análise de conteúdo temática. **Resultados:** As ações de vigilância foram realizadas, majoritariamente, por agentes comunitários, por meio de visitas domiciliárias às gestantes e às puérperas, com a finalidade de controlar agravos reprodutivos e de promover o autocuidado. O seu traço mais avançado foi à facilitação do acesso de mulheres às ações estratégicas do serviço local. A produção de informações em saúde reprodutiva, ainda que sistemática, não foi usada pelos trabalhadores no direcionamento das ações de saúde locais. **Conclusão:** A prática de vigilância analisada mostrou-se restrita, embora ampliada em relação à tradicional busca ativa para o pré-natal e à vigilância epidemiológica de agravos controlados.

Palavras-chave: Vigilância; Promoção da Saúde; Saúde Reprodutiva; Programa Saúde da Família.

Resumen

Objetivo: Analizar la práctica de vigilancia a la salud reproductiva en la Estrategia Salud de la Familia, en Cuiabá, Mato Grosso. **Métodos:** Estudio exploratorio, cualitativo. Se realizó la observación participante de prácticas en territorios de dos equipos de salud, entre enero y junio de 2012. En el examen empírico, se utilizó el análisis de contenido temático. **Resultados:** Las acciones de vigilancia fueran realizadas, mayoritariamente, por agentes comunitarios, a través de visitas domiciliarias a embarazadas y puerperales, con el propósito de controlar problemas reproductivos y promover el autocuidado. Su aspecto más avanzado fue la facilitación del acceso de mujeres a las acciones estratégicas. La producción de informaciones en salud reproductiva, aunque sistemática, no fue usada por trabajadores en direccionamiento de acciones de salud locales. **Conclusión:** La práctica de vigilancia se mostró restricta, aunque ampliada en relación a la tradicional búsqueda activa para el prenatal y la vigilancia epidemiológica de problemas controlados.

Palabras-clave: Vigilancia; Promoción de la Salud; Salud Reproductiva; Programa de Salud Familiar.

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INTRODUCTION

In Brazil, health surveillance is an important conceptual and practical milestone in the field of health, regarding the integrality guideline. Its main attribute is the focus on the reorganization of practices in order to include, in addition to the risks and damage, the needs and determinants of health[1].

There are several views of health surveillance historically developed. In a reformer effect, applicable to the practice of reproductive health in territories of the Family Health Strategy (FHS), its main directives are[1]: action planning based on the identification of risks, injuries/damages and determinants; emphasis on problems requiring continuous monitoring; actions of health promotion integrated with others; and people equitable access to the health care resources.

The actions of health surveillance in the FHS, nationwide, are guided by the Basic Attention National Policy (BANP). By this[2], surveillance is outlined in a restricted manner, as a technical measure for case and people search in areas such as identifying hazards, factors and risk groups and also as a notification of situations monitored through epidemiologic surveillance. However, in BANP, there are also propositions that match the broader sense of health surveillance, among others, the territorialisation, the offering planned based on the reality of life and health of the families, the building of solid bonds between these families and the local services and intersectoral actions and partnership. The policy innovates by proposing the challenge of building practices based on territorial considerations, i.e., by reckoning of how people live their daily lives and in what conditions, and transposing actions to the proximity of the territories-environments of their lives.

In this perspective, the reproductive health surveillance demands in ESF the recognition of individual and collective needs in this sphere, due to reference to the conditions of the everyday life and its social reproductions. Those shall be the base for the planning and execution of integrated and humanized actions of healing, prevention and promotion of care, mediated by relations of bonding and co-responsibility. In addition, surveillance should provide access for women and men to resources required by them, from health services and social network.

The perspective of this surveillance considers that reproductive health refers to the interrelationship between the biological dynamics of reproduction, the situations of life and culture that influence it, the organization and effectiveness of social actions in response to the needs in this sphere, the ways people experiment and give meaning to health, reproduction and care, as well as participate in the achievement of social rights that benefit them.

For the presented reasons, we considered important to look at the practice of reproductive health surveillance processed in the area of FHS program, due to the innovative character expected from it. In Cuiabá, the attention to reproductive health is focused within the services, as a constituent of programmatic actions, and there is some invisibility around what is done into the territories.

Moreover, the practice of reproductive health in this area has not been subject to current publications. National articles of the past five years thematize clinical and reproductive health education in the FHS, but not from the perspective of surveillance. Some studies focus on epidemiological surveillance of reproductive health problems, and there is only one study[3] on health surveillance, but for primary care as a whole. Held in São Paulo, this study found that workers conceive it in a wider sense, as a measure of control of diseases and situations of vulnerability, but they perform it in a traditional way, as an epidemiological surveillance, according to the biomedical model.

Therefore, this study asked: what are the characteristics of reproductive health surveillance in FHS areas in Cuiabá city scenery, and which social objectives guide it? This study aimed to examine this practice and recognize the perspective of surveillance it expresses.

Territorial health actions correspond to those performed in the spaces of people's life, in a way close to their everyday routine. These spaces are socially configured and are made of the everyday sociability, articulated to the social reproduction of life. The territories make up the health situation of the population that inhabits it, and the health is dialectically determined by these spaces[4].

METHODOLOGY

Operationally, the study was exploratory, with an unexplored subject. A qualitative approach was adopted, as we sought to understand the phenomenon in depth, without generalizing results[5].

We conducted the study in two FHS units of Cuiabá. This city has 63 family health teams, 60 being in the urban area. For the choice of units, the criteria considered was: be located in urban areas; have a complete health team, with participation of workers in the unit for at least six months; and no scholars replacing the workers in territorial practice. The goal was to ensure the participation of doctors, nurses and Health Community workers, since, in the city, these are the main agents of territorial practices.

One of the units studied was in charge of assisting 1,014 families from eight micro areas. The other was responsible for 1,274 families in nine micro areas. Inside the office, the two units provided prenatal, gestational and planning actions, and collection of material for the examination of cervical Pap smear (CCO).

The study included 12 community workers, two nurses and a doctor, a sample defined by exhaustion[6]. During data collection, in one of the territories, the doctor left the team, also leaving the study sample.

Data collect was done from January to June 2012. It was conducted by the first researcher through 190 hours of observation, as a partial observer of territorial actions in general and reproductive health, reproductive health actions into the services, weekly team meetings, meetings of the nurse with the community workers, and the actions of preparation and completion of routine territorial activities. Contact with the territories occurred with the intermediation of the community workers. It was recorded

in digital media dialogues that accompanied the corresponding actions; the witnessed was recorded in a field diary. We complemented the observed with informal interviews with those involved.

The thematic content analysis was the technique used[5]. We performed the initial analysis of findings by territory, using questions derived from the research question: which territorial actions of reproductive health surveillance were performed? Who and what were the subject of these actions? Which agents performed it? How? What purposes they aimed? The final categories were constructed from the previous junction of the core meanings found in both territories material.

In presenting the empiric, we used the N codes for nurses; HCA for the Health Community Agent; and D for the doctor; all identifiers followed by ordinal numbers. In the specification of the two territories we used the T1 and T2 code.

The study complied with the ethical guidelines for research involving human subjects, was approved by the Research Ethics Committee of the Júlio Müller University Hospital, Opinion Nº 089/2011, and the participants signed an informed consent term.

RESULTS AND DISCUSSION

The following items present and discuss the practice of reproductive health surveillance: what moves it, its agents, the technologies used and the purposes that guide it. The appointment of items summarizes the main features found: 1) the centrality of control actions, at home, risk and health problems of pregnant and postpartum women, by HCA; 2) the bias of the production and use of information on reproductive health; and 3) the bias of the articulation of women's access to resources and family health.

Centralization of risk control measures and health problems of pregnant and postpartum women, by HCA

In the territories of the studied units, reproductive health surveillance was accomplished primarily through home visits, designed specifically to reproductive issues. In other visits, designated for other purposes, when there was, in the house, women and/or men in full or near-full reproductive stage, there were no routine and timely actions of surveillance in the area.

The home visit is an important tool for health surveillance in the FHS. It can push the practice restricted to active search and surveillance of diseases. The visit allows us to know the sociocultural and intersubjective context of families, their experiences and perceptions of health, illness and care, the specificity of their problems, and also distinguish the needs in different areas and acting on them.

This care modality has provided advances in continuity of care and in the materialization of completeness. Through it, new ways to intervene are created, both in the ESF and in different points of the health care network, contributing to overcome the hegemonic attention model[7].

Into family context, men and women in different stages of life, bear peculiar reproductive needs and sometimes face social situations adverse to their health. Thus, the visit can be a way to talk about medical issues in context and also to cope with non-medical problems.

In practice analyzed, however, the visits served for the search for pregnant women for prenatal care, and women and partners for surveillance against syphilis, HIV and hepatitis B. In addition, the actions focused primarily on the gestational and puerperal process. The needs of women before conception, and the ones related to the exercise of motherhood, and completion of reproductive phase and regarding the sexual sphere, among other things, were incidental objects of action.

The man and the family also weren't subjects of assistance, except the first, eventually. The family was not considered in its participation in the care for the women and children. The same can be said about the man, who also has his own needs in there productive sphere and in the exercise of parenthood.

The approach regarding sexual health issues, when performed, was reduced to guidelines only. In this sense, for women, they focused on mammography and Pap smear (Cervical Cancer), and the use of contraceptives. For men, the guidelines were on the prevention of prostate cancer and sexually transmitted diseases (STDs). The transcription below summarizes the objects clipped in the surveillance practice and its prioritized actions:

> *Our duty is to guide, to bring health information to anyone. The first thing I ask is about mammography and Pap tests, I ask if they already have sex, because in 13 years of practice I already have some intimacy. I ask if they intend to become pregnant, I explain about contraceptive methods, about the risk of not doing the Pap test. We conduct some guidance in general. On men's health is the same. We ask: - How old are you? Oh, it's time to do the prostate exam! Did you ever? We talk about care in the polyclinic. You know men do not like doctors, especially they need to do prostate exam. We explain how important it is. We also talk about syphilis, chancroid, STDs (HCA5, T2).*

The preference given to the reproductive process of women is related to the cultural construction that takes it as a female event in a social context of inequalities and gender hierarchies between men and women. This construction, reproduced in the actions of services, influenced not only to the lack of attention to man as the subject of the shares in question, but also to the emphasis on the reproductive process itself.

A study[8] on the relationship between men and health care, developed in four Brazilian states, shows that the primary services investigated did not prioritize man in their actions, whose invisibility is related to the social imaginary of gender, which associates the female to health care and the male to professional carelessness.

By focusing on women's reproductive process, the practice of surveillance disregards other relevant questions to the reproductive health of men, and also to the pre and post pregnancy-puerperium cycle stages and the ones related to the links between reproductive health and the intersubjective and social processes.

The national guidelines for antenatal and puerperium[9] stages advocate for reproductive health surveillance: 1) uptake of pregnant women for prenatal care up to 120 days of gestation and its connection to the service for regular follow-up; 2) the pursuit of the ones missing on routine actions; 3) prevention of vertical transmission of syphilis, hepatitis B and HIV; 4) preventive immunization of neonatal tetanus and hepatitis B in women; 5) nutritional assessment of pregnant women and their monitoring by the Food and Nutrition Surveillance System; and 6) the attendance to consultation from 10 days and up to 42 days after delivery. The recent Policy for Integral Attention to Health of Men[10], although not listing specific surveillance actions, emphasizes men's right to access to reproductive health care and to the support on the exercise of parenthood.

Although these propositions are relevant, the reproductive health surveillance, in an innovative perspective, also requires the recognition and identification of the vulnerabilities of women and men with health implications in the sphere in question. With this we must consider more broadly than the currently established the social inequities, the lack of structure and conflicts of families, the gender patterns when on reproductive and sexual issues, as well as the potential men and women have, among other processes.

In this way, problems historically considered (unwanted pregnancy, impaired fertility control, STD) deserve attention, as well as others as violence between partners, drug addiction, prostitution, lack of social support for poor families, among many, whose negative effects demand health promotion actions.

The organization of basic health care in Cuiaba works on strategic actions whose implementation extends to the territories and maintains the individualized care. The priority given to this generates a devaluation of the collective actions, which is perceived in the absence of projects and systematic actions to promote health, such as the coping with vulnerabilities in interaction with other sectors, services and the territories themselves.

Health promotion seeks to improve the conditions and ways of life of people/groups and reduce their vulnerabilities related to their ways of living, thinking and acting - regarding their working conditions, housing, environment, education, leisure; social support to families, including access to essential goods and services, such as health care, among other aspects.

In the context studied, the actions evidenced here consisted mainly of responsibility of HCA, as part of their routine visits, in the micro areas. Nurses could fit visits to pregnant women at higher risk, to postpartum women up to 10 days from labor and to the ones unable to travel to the local service. At T2, this occurred with some regularity. At T1, nurses gave priority to activities inside the unit. The same happened with the doctor from T2.

The BANP assigns to the HCAs the primary responsibility for the actions in the territories, despite the complexity of them. Although it also shares them to other team members, such as physicians and nurses, at the FHS in Cuiabá, these have sole responsibility for actions prioritized into the unit, controlled by the productivity achieved. Thus, the consultations occupied much of the agenda of these workers, restricting their time for external actions, limited to one period per week.

This same feature was reported in another study on the factors that prevent, limit and facilitate intersectorality in the territories of units of FHS in João Pessoa, Paraíba. In it, it is noted that care demands within the unit consumed the time of professionals and restricted their actions in the territories[11].

It is worth noting that, in the scenario studied, despite the political guidance regarding assistance in FHS and the control maintained by the municipal administration, the workers participated in the definition of the contours for the practice in question. A sample is that, due to nurses' position, in T1 they remained distant from the territorial actions, while in T2 they were active in that.

In relation to the technologies used in the visits in both territories, there were questions about the welfare conditions of women and regarding the presence or absence of signs, symptoms or problems indicative of complications such as edema, vaginal bleeding, diabetes, hypertension, among others.

> *HCA: - The first consultation you did with M. was on April 3rd, and the next is May 2nd. Risk factors... [Looks at the visit script to pregnant women, prepared by the City Health Dept.]. Then asks: - You've had three pregnancies, no abortions. Now in this third pregnancy, you're 36, right? Any bleeding in this period? Pregnant woman: - No.*
>
> *HCA: - What about swelling, have you been feeling anything like it? Pregnant woman: - From time to time I feel that my foot swells.*
>
> *HCA: - Then you must talk about it with the doctor, ok? This is important. Question: - Diabetes? High blood pressure? Pregnant woman: - Nothing.*
>
> *[...] (HCA1, T2 - 36 year old pregnant woman, married, 3rd pregnancy).*

The nurses from T2 also did the physical evaluation, focused on a particular aspect, such as measuring blood pressure (BP), the glucose test, palpation of postpartum breast, among others.

In both territories, the HCAs controlled, using the records in the Pregnant Card, changes in weight and BP and the pre-natal check-ups. In T2, the HCAs also found pregnancy risks recorded on the card and, as they stated, used this to make sure that pregnant women were attending to prenatal consultations and following the guidelines. During the visits, the agents inquired the women about following the care recommended or considered important, which often were followed by the explanation of what they necessarily "should" do.

> *Nurse: - What about the diet? Are you doing it? Because this coffee... Pregnant: - Dad, at the morning, gives ice cream to her [daughter] and I say: - Dad, I'm already diabetic... [laughter].*

Nurse: - Really! Now he want to make her too [pointing to the girl]? Pregnant: It's what I say to Dad, he says that she wants [the ice cream] and I say what he is going to give her is diabetes.

Nurse: - So, you have to change these habits from childhood. You know that the child follows our example? You keep your diet! Pregnant: - I eat enough fruit and vegetables, and so does she. But it's just to go home to Mom and Dad! [...] (N2, T2 - 29 years old, married, diabetic, 20 pregnancy weeks).

In surveillance practice of T1 HCA, the most common action was the control of immunization of pregnant and control of contraception of postpartum women via inquiry and/or an indication of what they should do. In T2, the HCA managed, in particular, the implementation of prenatal examination and the use of prescribed drugs. In the nurse work, it was common the control of breastfeeding and certification of compliance with the vaccination schedule and the completion of the "Guthrie test" the newborn, through the same resources.

When the action was directed to pregnant women, the major concern of HCAs and nurses was any indicative manifestations of medical problems and with their self-care behavior. When directed to postpartum women, the action focused in particular on the behavior of the woman with the newborn and on breastfeeding.

Complementing the inquiries, the two agents had offered information and unsystematic guidance to women, especially on contraceptive use, breastfeeding, care of newborn, food and on ways to look for this service and other medical resources. Aspects related to experiments, points of view, interests and conditions of the assisted women had no space in these visits.

While examining the newborn, the postpartum woman expresses her concerns regarding the resumption to sexual activity:

Postpartum woman: - M., my husband already wants to have intercourse with me, but I'm kinda scared. Nurse: - What you're passing in this stump? [asked showing the umbilical stump of the newborn].

Postpartum: - Only alcohol. You know, when my boy was born it wasn't like this. Now, with her [the daughter] I'm having so much trouble, I'm so tired, I have no desire to have intercourse. But I do not want to lose my husband. Nurse: - Show me how you're cleaning the stump. The thing is, by now, it should have fallen.

The women took the swab moistened in 70% alcohol and showed how she did the cleaning. While performing it, the nurse asked: - How many times a day you're doing? Woman: - Once, after her bath. Nurse: - Oh, so that's it. You must do it three times a day, for it to dry faster and fall. After this speech, the woman stopped to express her concerns regarding their sexual activity (N2, T2 - postpartum woman, 22 years, two children, married).

The educational relationship established was based on linear transfer of information, about service resources available and "medical truths", linked to the call for some expected behaviors, historically common in health services.

From the characteristics presented, we perceived that the main purpose of the actions in the two territories was, regarding pregnant women, the prevention and medical control of pregnancy problems and, in the case of the mothers, fertility control and health of newborns.

The findings demonstrate a surveillance practice linked to the monitoring health risks to the population, applied to the reproductive sphere. This care perspective, historical in nature, has contributed to the social need for prevention of maternal, fetal and neonatal morbidity and mortality, which is a prominent example for prenatal care in the country.

The control of risks and problems on reproductive health emphasizes both prevention and care to medical complications, as early as possible. Hence the territorial practices, as analyzed, to take effect primarily through the investigation of risks and medical problems and through the indication of preventive behaviors.

From the biomedical point of view, the way of life of the patients are considered as cause of problems, so it is understood that they need to be modified, based on what is judged as "correct" behavior. This possibility is founded in the social acceptance of medical practice as a legitimate source of facts, and an institution of social control[12].

The vision of health that can be seen from this perspective makes it widely dependent of behaviors considered "adequate". Consequently, the questions about what was done are valued, and are coupled with informational educational measures. Thus, the workers control the behaviors in reproductive and sexual sphere, and indicate available resources that enable them, as contraception measures, condoms, immunization, the service search, tests, and others.

In the current model, attention to reproductive health as a whole is oriented to the purpose of preserving the female reproductive biology, the biopolitical control of reproduction, and to strengthen the social role of woman in motherhood. There is, in this model, a set of guidelines to be passed, about control of risks and hazards involved in fertility and maternal and perinatal morbidity and mortality, and about control of ideas, values and attitudes related to conception and contraception, maternity and paternity, and regarding self-care to reproductive and sexual health.

Surveillance to risks and reproductive health problems as part of preventive actions is a practice recognized for its beneficial effects, both in territories and into the local services. However, they are limited, from an innovative perspective of reproductive health surveillance.

In this latter perspective, respect for the protagonism of the people and the politicization of reproduction are important

elements. Thus, the educational sense of the actions must be committed to women's and men's government, of their lives and health. For this, it is essential their active participation all the time at the visit and, through different strategies, the workers must make them speak, inform, reflect, and decide.

Moreover, territorial action must be committed to the participation of the group in the achievement of better living conditions and health in the territories. This requires strengthening community action, through an increased political and technical power of individuals and groups. The commitment to the strengthening of individual and collective capabilities of these is an element involved in facing determinants and constraints of health[13].

Partiality of the production and the use of information that brings professional actions close to the reality of life and local reproductive health

The HCAs held much information about the conditions and ways of life and health of pregnant and postpartum women, due to the daily contact they had with the families, due to the fact of sharing the same reality of their lives and due to the surveillance visits conducted.

Some of this information were taken to the units. At T1, this happened through direct contact between HCA and doctor or nurse, by the judgment of the first.

> *We always take to the doctor the people who need to be visited visit during the week, usually the elderly, with expired prescriptions, the bedridden, those who say they are not feeling well. For nurses, we also inform about the pregnants with a problem and the ones who had babies recently (HCA3, T1).*

It is known that the proximity among the workers of the families and the circulation of information between them, especially with the intermediation of HCA, as noted, provides recognition of the local reality of reproductive health and the integration of actions to that.

In this sense, data/information on visits also were produced, recorded in the corresponding charts. But it happened systematically in T2 only, gathering data on complaints, physical conditions and general behaviors. The information recorded focused on clinical aspects. The records did not follow a methodology, were simple and incomplete, and so they do not have enough value as a way of articulating actions.

The transfer of information from territories also occurred in the team weekly meetings. On occasion, HCAs placed on debate issues such as the refusal of registration, change of address, and the difficulty of establishing a link with certain families. Nevertheless, the meetings consisted mainly of a space for transferring to the employees information from the Municipal Health Department.

The team meetings are considered proper spaces to the socialization of information and to collective planning of assistance actions. Thus, they should be used for collective decision-making, based on the discussion of the situations found in the territories and on an interdisciplinar perspective[14]. To do so, the team production and access to systematized information about the local reality, from established indicators, are essential because they allow better planning and execution of actions in the territories.

In this sense, the HCAs collected data systematically for the Information System for Primary Care (SIAB), on living conditions and health of families, raised through registration actions which are continually updated in accordance with a nationally standardized instrument (Form A).

The collection of specific data from pregnant women occurred by completing the Pregnant Data Monitoring Report (Form B-Ges), which contains: the date of the last menstrual period; the expected date of labor; the date on tetanus immunization; nutritional status of pregnant women; the date of prenatal visits; Gestational risk factors; the number of successful childbirths, stillbirths and/or miscarriages born in last pregnancy; and the date of postpartum consultation. Further information on reproductive health were systematized in the Health Monitoring of Families Status Report (SSA2 Report), which includes: number of pregnant women registered and monitored by the service; number of pregnant women with tetanus vaccination scheme updated; number of pregnant women who underwent prenatal consultation in the month; number of women who began prenatal care in the first trimester of pregnancy; number of pregnant women under 20 years old and enrolled in SISPRENATAL.

The comprehensive practice of health surveillance understands the territory as a place where the social relations of production and social reproduction occur. Work practices must be immersed in this context, presuming the full exploration of the territories, according to the logic of the relationships between living conditions, health and the access to health services[4].

The different health problems are individually experienced but are socially configured. And so they need to be recognized in the territories, as a need of the community, for, through them, establish the care priorities and the means to serve them[4].

Although they bear this importance, in the analyzed territorial practices, the indicators of public health capable of being produced from the SIAB, as established by the Ministry of Health, were not used in the recognition of local socio-epidemiological features, including those related to reproductive health.

It is important to consider, also, that the information capable of being generated in this system are insufficient to arrest the social exclusion faced by women and men, as well as the identification of their vulnerabilities which come from the interrelationship between family socio-cultural conditions, access to social services and practices and knowledge in reproductive and sexual health.

In other words, in reproductive health surveillance it is essential the production of general and specific information related to the territories, through a variety of sources and resources, and they must match the definition of actions. This task is the key to

reach the reading of the specificity of reproductive health and illness situations and expressions in the territories.

Partiality of articulation of family and women's access to resources that promote reproductive health

The reproductive health surveillance analyzed also fulfilled the purpose of facilitating the contact, especially women, with health resources needed, although this has occurred in part only.

We observed the action of facilitating women's access to local service, for investigating a possible pregnancy, for prenatal, for postpartum consultation and for the newborn, for the CCO and breast examination, and facilitated the reach to technologies such as condoms, vaccines, drugs, and others. To that end, HCAs scheduled consultations, accorded it with nurse or physician, provided information for seeking care or for access to the available resources, as well as accompanying women to the service.

In T2, the nurse was responsible for facilitating women's access to reference services of secondary and tertiary (polyclinic, reference laboratory, maternity) level, by offering information and referrals.

These characteristics indicated are consistent with an axis of reproductive health surveillance, since it seeks to expand the access to health care actions. Benefitting women's contact with the local service and reference services and resources makes them to be better monitored in their reproductive health condition, as well as provide a continuity of care.

A study[15] aimed to understand the significance of the relationships and interactions of the HCA network, in a health unit in Florianópolis, pointed out that these agents, facilitating the access and giving value to the services, stimulated the formation of the bond.

This element is essential for the acceptance of women and men to participate in the services for the care of their reproductive health. The promotion of the bond provides the attendance to FHS not only in pregnancy and puerperal moment, but permanently, triggering what is called as longitudinal bond[16].

Besides facilitating access to health services, in T2, the nurse also arranged woman's contact with an existing social service in the community, the Social Assistance Reference Center (CRAS), through the provision of information.

> *Nurse visiting a pregnant woman: - Are you already part of the Family-Sponsorship Program? Pregnant: - not yet.*
>
> *Nurse: - Why not? You're about to have a second child. Pregnant woman: - I do not know how to do it.*
>
> *Nurse: - You'll have to go to CRAS. There they will make your subscription. You present the birth certificates of his daughter and the baby, if he has been born, your Id register or voter registration card, a utility or water bill to prove residence and the children's vaccine card. If your girl is already in school, you would also have to take a statement from the school that she is studying. Pregnant: - Is that all I need?*
>
> *Nurse: - It is. But it takes time to enter the program. You have to be patient. (N2, T2 - 29 years old, married, diabetic, 20 weeks of gestation).*

However, we did not identify formal articulation with this service or articulation of other features of the social support network, although workers point it as part of their practice, due to social conditions of families construed as unfavorable.

> *Once I arrived at the house of a parturient woman to see how she was. She had had a baby a week ago. She ran out of diapers and baby barely had what to wear. The husband drank and was unemployed. The family could not afford to help. When I returned to the office, I told the story to the staff and we organize a raffle. With the money from the raffle we bought clothes and diapers (CHA2, T1).*

The connecting movements found corresponded mainly to the emphasis on the control of organic problems of reproduction and behavior of pregnant and postpartum women through biomedical know-how. As a result, it prioritized the coordination with the local service and reference health services.

It is historical the distance between health services from other important social resources in the production of health, and their employees are often unaware of what exists in this direction and its potential. Even the families are not recognized as part of the social support network, although active in caring for health[17]. This is extended to the sphere of reproductive health.

For the reproductive health surveillance of persons/families to be effective, local health workers should exercise a coordinating role across the various existing resources, in the connecting movements between families/members, local services, other health services and other supportive social network resources.

Social networks are a system composed of people, tasks and situations that provide material or financial and emotional support to people in their different needs[18]. By connecting these resources, workers create care spaces capable of meeting the needs that local and referral services alone are not able to perform. There is no way to conduct a broad surveillance without valuing health promotion; and no way to enforce this without taking the social health support network into account.

FINAL CONSIDERATIONS

The reproductive health surveillance practice found was set with traditional features, being mostly carried by HCA through visits targeted to pregnant and postpartum women, with the purpose of controlling reproductive diseases and promotes self-care behavior considered appropriate. Its most advanced trait corresponded to the facilitation of access, especially to women, to local service for prenatal and postpartum and newborn consultation.

The change in such practice should be designed and implemented in the midst of efforts to build the Health System (SUS) in

the country and specifically in the reconstruction of work processes in health, especially in the FHS. In this sense, every practical technical-scientific effort, each ethical and political commitment that moves with the established social forms to produce health through professional practice is relevant.

To modify the predominant perspective of reproductive health surveillance, it is important that health workers know what shapes their conceptions and practices - the hegemonic rationality working in the sector, among others - and how those reinforce the established rationality, hindering significant transformations.

In order to give value to the dialectical possibilities of transformation that everyday practice creates, it is important to invest in overcoming the understanding of reproductive health as something related only to the female organic realm, and dependent on individual practices oriented to prevention and cure. We should invest in building a new subjectivity for workers through new training models and through the education of health teams, so that the practices also assume the sanitary duties.

Although the results of this research cannot be taken as general, as in all qualitative research, they serve to the understanding of similar social processes. This research allows us to reaffirm that theory-to-practice translation of what to do to promote reproductive health, given its relationship with conditions and ways of life, with the participation and empowerment of women and men is an important path to pursue, in the practices of education, assistance, management and production of knowledge itself. In this latter sense, the new researches that result in technologies applicable to an innovative surveillance practice are essential.

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